

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

INTAKE APPLICATION - 3 YEARS AND OLDER

ASSISTS I.D.

1. APPLICANT'S NAME <i>(Last, First, M.I.)</i>	2. DATE OF BIRTH	3. SOC. SEC. NO. <i>(Voluntary)</i>
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4. DESCRIBE YOUR PRIMARY CONCERN / DISABILITY AND WHEN IT BEGAN

☐ Autism
 ☐ Cerebral palsy
 ☐ Cognitive disability
 ☐ Epilepsy
 ☐ Developmental delay

5. MARITAL STATUS <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Married	6. SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	7. TOTAL NO. IN HOUSEHOLD
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8. ETHNICITY <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Other:	<input type="checkbox"/> Native American <input type="checkbox"/> Living on reservation <i>(Tribe):</i>
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9. CURRENT SCHOOL/DISTRICT *(If applicant is under 22 years of age)*

10. REFERRAL SOURCE, ADDRESS AND PHONE NO.	REFERRAL DATE
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11. LANGUAGE SPOKEN BY APPLICANT <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Native American: <input type="checkbox"/> Other:	LANGUAGE SPOKEN BY FAMILY / RESPONSIBLE PERSON <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Native American: <input type="checkbox"/> Other:
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12. LEGAL GUARDIANS *(Attach copy of court order if applicable)*

NAME <i>(Last, First, M.I.)</i>	RELATIONSHIP	HOME MAILING ADDRESS <i>(No., Street, City, State, ZIP)</i> AND PHONE NO.

13. BIRTH PARENTS *(If different than above)*

MOTHER'S NAME <i>(Last, First, M.I.)</i> <input type="checkbox"/> Absent	HOME MAILING ADDRESS <i>(No., Street, City, State, ZIP)</i> AND PHONE NO.	EMPLOYER'S ADDRESS <i>(No., Street, City, State, ZIP)</i> AND PHONE NO.
FATHER'S NAME <i>(Last, First, M.I.)</i> <input type="checkbox"/> Absent	HOME MAILING ADDRESS <i>(No., Street, City, State, ZIP)</i> AND PHONE NO.	EMPLOYER'S ADDRESS <i>(No., Street, City, State, ZIP)</i> AND PHONE NO.

14. CHILDREN / OTHER ADULTS IN THE HOME

NAME <i>(Last, First)</i>	RELATIONSHIP	BIRTH DATE	NAME <i>(Last, First)</i>	RELATIONSHIP	BIRTH DATE

15. EMERGENCY CONTACT

NAME <i>(Last, First, M.I.)</i>	RELATIONSHIP	HOME MAILING ADDRESS <i>(No., Street, City, State, ZIP)</i> AND PHONE NO.	BUSINESS PHONE NO.

16. DIRECTIONS TO HOME

17. BENEFITS / EVALUATIONS / SOCIAL SERVICES OF APPLICANT *(Complete / check all that apply)*

SERVICE	MONTHLY AMOUNT	CURR. REC.	WILL APPLY	HAS APPLIED	EFFECTIVE DATE	PAYEE'S NAME	COMMENTS
Earned							
SSDI/SSA							
SSI							
VA							
RR							
SPP <i>(Supplemental Payments Program)</i>							
CRS <i>(Children's Rehab. Services)</i>							
Pilot Parents							
AZ School for Deaf and Blind							
Behavioral Health							
Other							
TOTAL PER MONTH							

18. MEDICAL COVERAGE *(Third party liability)*

TYPE OF COVERAGE	NAME OF PLAN	POLICY HOLDER'S NAME	ADDRESS AND PHONE NO. OF INS. CO. <i>(No., Street, City, State, ZIP)</i>	ID OR GROUP NO. AND POLICY NO.	EFFECTIVE DATE
AHCCCS					
ALTCS					
CMDP					
TriCare					
Medicare A					
Medicare B					
Medicare D					
IHS					
**Private					

If **Private is marked, specify by checking all boxes that apply.

☐ HMO ☐ PPO ☐ Standard ☐ Hospital ☐ RX ☐ Out-patient ☐ ER ☐ Dental
☐ Other:

19. PRIMARY CARE PHYSICIAN'S NAME, ADDRESS *(No., Street, City, State, ZIP)* AND PHONE NO.20. CURRENT / PAST MEDICAL CONCERNS *(Allergies, Hepatitis B, etc.)*

☐ Yes ☐ No Are immunizations current?

21. HOSPITALIZATIONS AND / OR MAJOR ACCIDENTS

WHERE	WHEN	OUTCOME

☐ Yes ☐ No Were accident claims or lawsuits filed?

22. LIST ALL EDUCATIONAL / PROGRAM / JOB HISTORY, PAST AND PRESENT (Most recent first)

NAME AND ADDRESS (No., Street, City, State, ZIP)	TYPE OF SCHOOL/PROGRAM/JOB	DATE(S)

23. LIST PROFESSIONALS CONTACTED, PAST AND PRESENT (Doctors, psychologists, therapists, etc.)

NAME AND ADDRESS (No., Street, City, State, ZIP)	PURPOSE OF CONTACT/VISIT	DATE(S)

24. INDIVIDUAL / FAMILY NEEDS AND CONCERNS

SOCIAL / EMOTIONAL (i.e., peer interaction, appropriate behavior) DO YOU HAVE ANY CONCERNS?

COMMUNICATION / LANGUAGE (Verbal and non-verbal) DO YOU HAVE ANY CONCERNS?

RECEPTIVE (i.e., responds to noise, voice, vocalizes sounds, responds to name / commands, comprehension):

EXPRESSIVE (i.e., vocalizes other than crying, laughs, vocalizes consonants/vowels, imitates sounds / words, uses jargon speech, says words, combines words, names pictures, uses short sentences):

HAS THERE BEEN SPECIAL DIFFICULTY ACHIEVING ANY OF THESE SKILLS (eating, movement, social / emotional, communication)

DO YOU HAVE ANY OTHER CONCERNS REGARDING DEVELOPMENT?

HAS THE APPLICANT HAD ANY CHILDHOOD / OTHER DISEASES? IF YES, PLEASE EXPLAIN.

HAS THE APPLICANT HAD CONVULSIONS OR SEIZURES? IF YES, PLEASE EXPLAIN

CURRENT MEDICATIONS AND PURPOSE

25. NEEDS AND SERVICES IDENTIFIED BY INDIVIDUAL AND / OR FAMILY *(Also include medical supplies, adaptive equipment, HCBS, etc.)*

IF ELIGIBLE:

- ☐ I would like the opportunity to choose my own support coordinator, if possible
- ☐ Please assign my support coordinator

COMPLETED BY

DATE

DDD INTAKE WORKER'S NAME

Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975, the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, and disability. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact the Division of Developmental Disabilities ADA Coordinator at 602 542-0419; TTY/TDD Services: 7-1-1.